Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH
5555 FREDERICKSBURG ROAD 102
SAN ANTONIO TX 78229

Respondent Name

UNIVERSITY HEALTH SYSTEM

Carrier's Austin Representative Box
Box Number 42

MFDR Tracking Number
M4-11-3017-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Partial payment was received for the above mentioned dates of service on 2/16/11. Payment for each date of service was paid at $100 per hour. Each date of service included notes for group therapy and physical therapy. For 1/10/11, 5 group notes were submitted and 1 physical therapy note. The physical therapy note indicates 240 minutes (4 hours) were applied that day. On this day, 9 hours were billed for [Claimant]…Lastly, a Daily Activity Sheet was included with the billing for these dates of service. This was a complete breakdown of all the physical therapy exercises done, and the amount of time spent for each date of service, with [Claimant]." "It appears only the daily group hours we billed were paid."

Amount in Dispute: $1090.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2011 January 11, 2011	Chronic Pain Management – CPT code 97799-CP (9 hours)	$265.00/day X 2 = $530.00	$00.00
January 12, 2011 January 13, 2011	Chronic Pain Management – CPT code 97799-CP (8 hours)	$280.00/day X 2 = $560.00	$00.00
TOTAL		$1090.00	$00.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 14, 2011
   - 18-Duplicate claim/service.

   Explanation of benefits dated April 8, 2011
   - 193K-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. * Previous recommendation was based on the number of hours documented in the medical records.*
   - 151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

Issues

1. Did the submitted documentation support the number of hours billed?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent denied reimbursement for the chronic pain management service based upon reason codes "193K-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. * Previous recommendation was based on the number of hours documented in the medical records.*"; and "151-Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."

   The requestor states in the position summary that "It appears only the daily group hours we billed were paid."

   The requestor submitted the following documentation to support billed services:

DATE	DOCUMENTATION	SIGNATURE	NO. OF HRS DOCUMENTED	NO. OF HRS PAID
January 10, 2011	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (1-2) Daily Group Progress Note (3-4) Daily Group Progress Note (4-5)	Andrea Zuflacht, M.S., LPC Lesley Casias, M.S., LPCI	5	5
	Progress/Treatment Note (No start or end time listed)	Thomas Washington, PT, MBA, ATC	0	0
	Conditioning Program (3:15)		0	0
January 11, 2011	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (1-2) Daily Group Progress Note (2-3) Daily Group Progress Note (1 to hr)	Andrea Zuflacht, M.S., LPC	4	4
	Progress/Treatment Note (No start or end time listed)	Thomas Washington, PT,	0	0

		MBS, ATC		
	Conditioning Program (3:30)		0	0
January 12, 2011	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (11-12) Daily Group Progress Note (12-1) Daily Group Progress Note (2-3)	Andrea Zuflacht, M.S., LPC	5	4
	Progress/Treatment Note (No start or end time listed)	Thomas Washington, PT, MBS, ATC	0	0
	Conditioning Program (No time listed)		0	0
January 13, 2011	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (2-3) Daily Group Progress Note (3-4)	Andrea Zuflacht, M.S., LPC	4	4
	Progress/Treatment Note (No start or end time listed)	Thomas Washington, PT, MBS, ATC	0	0
	Conditioning Program (No time listed)		0	0

The Division finds that the requestor's documentation does not support billing for the four hours of therapeutic services. As a result, additional reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support additional reimbursement sought by the requestor. The Division concludes that the requestor did not support its position that additional reimbursement is due. As a result, the amount ordered is $00.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature | Medical Fee Dispute Resolution Officer | 4/25/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.